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AUTHOR Stein, Myron; Ronald, Doris
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ABSTRACT

Educational psychotherapy for preschool children and its functioning are described in detail. Also described is the process of training teachers to do this work. The educational psychotherapy process attempts to operate at the interface between education and psychotherapy. The components of catharsis, recall, sharpening and correcting of perceptions, correction of projections, and emphatic insistence upon adaptation to everyday reality are all parts of the work of educational psychotherapy. The method is particularly appropriate for the young age group. The training of teachers is carried out in a formal two-year training program in which each trainee spends a minimum of 12 hours per week. At least six of the hours are spent working with children and their families, and six are didactic and supervisory. Each trainee must have treated at least three children, of various diagnostic categories, and their parents over the two-year period, and must have participated in the evaluation process with observations and brief trial therapies. Trainees are required to have, or are encouraged to work toward while in training, New York State Certification in Early Childhood or its equivalent. On completion of training, the educational psychotherapist can go into schools and day care centers, can become a mental health resource person, or can become a mental health professional. Two clinical examples are given of the educational psychotherapy process. (DB)

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EDUCATIONAL PSYCHOTHERAPY OF PRESCHOOLERS*

By: Myron Stein, M.D.
Doris Ronald**

Educational psychotherapy for preschoolers is a therapeutic modality in which selected preschool children are worked with individually by teachers under psychiatric and educational supervision. The parents are also seen by the teachers in guidance and information-exchanging conferences.

This report describes educational psychotherapy and its functioning in detail. Also described is the process of training teachers to do this work.

PRECEDENTS: Every nursery school and day care center has children who need special attention because of emotional disorders. Often the teachers, directors and consultants arrange to have one teacher or student or volunteer "special" such a child, working one-to-one with that child alone as much as possible. Often this is not possible because of personnel limitations. This practice often helps the child to gradually move from being a lost isolated infant to becoming a part of the group, and to learn to relate,to socialize, and to function more appropriately.

Some children require one-to-one help for longer periods of time, while for others a school may not be an optimal placement. Often, however, there is no other placement to choose from. If referred to a clinic for psychotherapy, the very young child is frequently refused (Turkel, A. 1968). Although efforts are being made to increase the availability of therapies for preschoolers, only a very limited amount of treatment is available to very young children and their families (Stein, M. 1968).

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When very young children in need of assistance with developmental disturbances or lags are seen in clinics for psychotherapy, the therapy is often unfocused, and without clear method and established goals beyond playing with the child and meeting with the parents. This can go on for a long time and often therapists "adopt" the children and their families, seeing them for many years. In reviewing therapies described as relationship therapies, we note that therapists who try to provide the child with some insight frequently have the impression that the child has not been able to utilize interpretations. Frequently there is improvement anyway, because of the therapeutic relationship.

In attempting to develop a more specific therapy, more exactly suited to the needs of very young children, Dr. Augusta Alpert evolved a psychotherapeutic method called Corrective Object Relations (Alpert, A. 1959). She used warm, motherly persons to do this work. Some of them were not professionally trained, others were teachers, psychologists, and social workers. Under her analytic supervision, these therapists worked with children on a one-to-one basis intensively, many times a week. They also met with parents. In sessions with the children, the therapists allowed and attempted to facilitate regression. Working with children suffering from pathological fixations due to maternal deprivation, she found that, when young children of two to five years of age (preferably 2-4) were given the opportunity to regress in a warm, mothering relationship, they were sometimes receptive to what became a "restitutive mothering" provided by their therapists. Following a period of Corrective Object Relations, the children would, at their own rate, move out of the COR therapy and sometimes show a greater readiness for other therapies when indicated. Many of these COR children then moved into an analytic psychotherapy, a therapeutic nursery, or other therapeutic modalities where needed. Sometimes the COR sufficed and further treatment was not indicated.

At the Child Development Center in New York City, Dr. Peter Neubauer, Dr. Annemarie Weil and others have, for many years, utilized teachers to work one-to-one under psychiatric supervision with preschool children and their parents. Sometimes such children came for evaluation for a developmental lag, or a specific area of mal-functioning. Sometimes the child could not play, had difficulty in relating, had other specific areas of difficulty such as lag in the development of speech. It was found by Dr. Neubauer and others (Neubauer, P. 1960), that teachers who were used to working with very young children, were particularly adept at helping such children to progress in their interrupted development. Working through a close, warm, exclusive, intimate relationship, the teacher frequently had marked success in helping the child with his developmental tasks. She helped him to relate more intimately and more trustingly, and to communicate. Out of this relationship and communication, she helped to channel his energies to an interest in learning, in his perceptions, and in other people. Conversely, by sharing these processes with the parents, the parents could often be helped to improve the parenting function themselves through identification with the teacher, through

education as to child rearing, and through emotional support.

It is our impression that in these precedents and others, the professionals are responding to the special needs of many preschool children. These are children who do not possess the capacity to utilize an interpretive therapy at that particular time, although many other preschoolers can be treated analytically. Often the former are children who are not yet able to function in a school situation, but who require an approximation of a mothering, one-to-one situation before they can move on to either schooling, interpretive therapy or to accepting and utilizing the parenting available to them in their own families.

The meeting of the child at his level and helping him with his developmental tasks in a supportive, reality oriented, teaching fashion is, we feel, often particularly helpful. We find, as have others, that the preschool teacher, usually a woman, is often more adept at working with this age group in this manner than are other professionals who traditionally do analytic therapy with preschool children.

EDUCATIONAL PSYCHOTHERAPY FOR WHOM? THE PATIENTS: Children and their families on referral to the Center for Preventive Psychiatry are given careful psychological evaluation in which developmental, dynamic and genetic formulations are made including profile assessments of the children (Freud, A. 1962; Neubauer, P. 1965). Sometimes parents are sufficiently well constituted, and children sufficiently advanced and neurotically conflicted in their functions as to be able to utilize an analytically oriented therapy aimed at producing insight as well as intrapsychic change. We do such therapies even with a multi-problem family living in chronic crisis if there is enough strength in the child and enough support from even one parent. This process has been described by Stein and Feinberg in 1970, "The Analytic Psychotherapy of a Disadvantaged Black Child."

Many times, however, there is not sufficient support for the therapeutic process or strength for participating in it by parent or child, not only in multi-problem families. Frequently we find that these children have major developmental lags which do not permit them to function adequately in day care centers, although they are usually kept on in such centers by necessity. Sometimes they are helped in the centers but it is clear that they need more individual help, of a supportive and non-interpretive nature. Often such children require concrete, "meat and potatos" warm giving to help them confront any of their difficulties. Such is not the child for analytic therapy. It is our impression that a more relevant approach for such children is that of a specially trained teacher who can accept them where they are and then make appropriate, specific, goal-oriented developmental demands of them.

There is a danger that such an approach can become trite, vapid and unfocused. We go to great lengths to constantly reaffirm and reassess the goals of the educational psychotherapy so as to make the therapeutic process as specific a one as possible.

CLINICAL ILLUSTRATION: A four-year old child was brought to the clinic by his mother. He was referred there by his nursery school because of inability to participate in class, and tenseness which led to his description as hyperactive. He did not speak at his age level, and sounded like a much younger child. He was unable to function without the one-to-one attention of a teacher. The mother described him as depending on her constantly, clinging to her, needing her every minute lest he be anxious, upset and "unable to do anything." The mother had married at the age of seventeen to get out of the home where she was unhappy. Shortly thereafter her husband left her, when she was already pregnant with the patient. In recent years she has been away from the child while she worked, doesn't know how to handle the child, what to do for him or with him.

In this very sparse vignette we see a case which is, in many ways, typical of those which come to clinics. Some are more severe, of psychotic proportions, some are of children who are retarded.

In this case it was felt that the mother was the prime patient and had to be the focus of the treatment. Clearly she required guidance in dealing with this child. It was felt that some work with the child was necessary, but that the under-mothered child was not a good candidate for analytic psychotherapy. This is the sort of child who could use educative help to progress towards effective functioning. If he were retarded or psychotic, which was not the case, we would have a better idea of how to classify his needs although we might have great difficulty in satisfying them. It is such an in between child with developmental lag, often with multiple early childhood deprivations, who doesn't fit into the usual psychotherapeutic categories. He does, however, fit quite well into the broad group who can be worked with by educational psychotherapists. For example, in this case this child specifically needed to learn that he could establish a relationship with an adult who could be warm, giving, reliable, responsible. With this as a basis it was suggested that he could eventually learn to communicate verbally and through play, to further express, ventilate and have catharsis of his tensions and concerns. An additional focus of the educational therapy for such a child was the multi-modal clarification of the ambiguous and uncertain atmosphere in which he lived. Further modalities for clarification would include discussion of other facts with the child according to his readiness. The educational psychotherapist would guide the mother and share with her the experiences of working with the child to help her to do more with him herself. In such a needy, inadequate and primitive mother with her own insistent, unsatisfied, infantile needs, the identification with the therapist and the sharing of the actual experience of working with the child is particularly important. Hopefully, in time the mother's guidance would help her to further accept and develop her role as mother. The prognosis for the mother is limited as to her capacity to accept the recommendation for, or to utilize insight therapy. It is not as limited in regard to her working on a more superficial, guidance,

identifying level with the educational psychotherapist whom she can learn to want to please and emulate. The child's experience of relating to a more mature adult might free him sufficiently so that he could move on from his developmental fixation, take advantage of the developmental push, and transact with increasing mutual gratification with his mother.

Sometimes children come for evaluation who are viewed as retarded or autistic. If we feel that we are dealing with a pseudo-retarded or pseudo-autistic child on the basis of careful scrutiny of the child's ability to relate and to function, we may take such children into an educational psychotherapy program. The teacher does prolonged observations in which she holds twenty or more sessions with the child (sometimes this is filmed) to facilitate a careful distinction between the pseudo-retarded and autistic and the children who seem to actually be retarded and autistic.

Some children on finishing in an analytically oriented psychotherapy or graduation from the therapeutic nursery, may have to go back into a chaotic multi-problem situation, or may be faced with new difficulties requiring a supportive professional presence. We have utilized educational psychotherapists at such times also.

THE EDUCATIONAL PSYCHOTHERAPEUTIC METHOD: The first step in educational psychotherapy is the initial evaluation including a very complete developmental history, interviews with the family, a psychiatric examination, psychological testing, and, where indicated, periods of observation and trial therapy to clarify the diagnostic questions. In a negative sense, we refer children for educational psychotherapy when they lack group readiness, or the frustration tolerance to utilize groups, and the self observation capacity necessary to use interpretive therapy optimally. In the positive sense we refer children who tend to be like those mentioned in the precedents: maternally deprived, those of multi-problem families and children in chaotic situations. Often children with various specific developmental lags of psychogenic origin (e.g., speech lag, lag in ability to communicate, to play, to control oneself). Etiologically our educational psychotherapy patients tend to be products of parental insufficiency and toxicity combined. We are careful to set goals as specifically as possible for these children with massive, broad spectrum needs, and to build a professional rationale in the therapeutic process. Needless to say, this work cannot be done by over-intellectualized persons who do not know how to genuinely relate to children. We think of the process as utilizing psychological insight and understanding and translating it into teaching method. This will be illustrated.

Other types of educational therapies are done with primarily older children. These include reading therapies, tutoring, speech therapies, etc. These treatments are not generally employed at the Center. Our educational psychotherapists concentrate on emotional needs which give rise to developmental lag and deviation. Sometimes these lags or deviations will lead to such difficulties as speech disorders. In these cases we will work in tandem with speech therapists or other special therapists where indicated.

With older children, primarily those moving out of nursery school and into the primary grades, the educational psychotherapist sometimes does work on reading readiness and the three R's. Academic achievement is not our primary goal but some children reach a level at which this is the area of their interest. Involvement in learning of a school type can be helpful in developing positive feelings while working with an interested, concerned, communicating educational psychotherapist who understands the dynamics of the learning difficulty.

The teacher is careful not to take advantage of the precocious preschooler's needs to gain approval by the precocity. We lean towards preferring to work with a child's more primitive needs rather than to exploit the precocity and seal off the possibility for work on a more basic level. The subsequent intellectuality which can develop a more solid foundation is usually more satisfying, long-lasting and extensive.

When the recommendation in educational psychotherapy is for a Corrective Object Relations therapy, the guidelines of Dr. Alpert are followed. A situation is established in which regression of the child is made possible, although not pressured. Restitutive mothering is the goal of Corrective Object Relations, and this is done along the specific lines of the child's needs which are elaborated in the therapy, and are evaluated psychologically as the process goes on.

With some children the neediness and reaction to it is expressed in aggressiveness to others, often as an expression of the anger at unsatisfied needs. As Dr. Brody demonstrates in her work with infants, one of the prime factors in dealing with young children is firmness lovingly applied (Brody, S. and Axelrod, S. 1971). This firmness can be and often is an essential feature of working with such children. Without this the child continues to be anxious and continues to be aggressive as a way of expressing many things including an attempt to control the anxiety. The educator can supply limits without disrupting the therapeutic process (Ronald, D. and Kliman, G. 1970).

In the course of working with children in educational psychotherapy (or in any nursery) a great deal of rich dynamic material is expressed. Extremes of handling this are for the nursery school teacher, or the educational psychotherapist to be uncomfortable with it, embarrassed by it and to ignore it; or for the avidly psychologizing teacher to do inappropriate and usually ill-founded interpretations of the material. The role of the nursery school teacher in dealing with this and other mental health issues in the classroom is discussed by Stein and Beyer in "Beyond Benevolence: The Mental Health Role of the Preschool Teacher," 1969. This paper describes work with the Sarah Lawrence College Nursery School teachers to help them to function more adequately in aiding children and parents with mental health issues, retaining their identity as educators, and without becoming interpreters or wild analysts.

For the most part our problem has been to help our trainees to listen, acknowledge, and react to dynamic communications, and to

overcome their feelings of being busybodies in so doing. Unless the teacher acknowledges charged issues, the child is left in limbo, made anxious and tends to withdraw from the teacher. It is our experience that such communications can be dynamically understood but handled educationally rather than interpretively.

One example of this is of a five-year old child who tells the story of a lonely frightened girl (related to her situation) then asks urgently, "What time is it?" The urgency to know the time and to leave fits her past pattern of expressing fear and then needing to run from the sessions. If her communicative behavior is ignored, the child will continue to be anxious and will need to run. It is the experience of the educational psychotherapists that it is not necessary, however, to make an interpretation, genetic or otherwise about the loneliness of the child when her mother left when she was younger, and the need to run now to escape loneliness. We also need not discuss her turning passive experiences of abandonment into active departure. It may be helpful to educationally affirm for the child that many children are lonely and frightened and that this can be very hard for any child to deal with. If the urgency of time continues despite the acceptance of the original communication and the universalizing of it, then the teacher can acknowledge the communication and tell her that there is lots of time for them and there will be a constancy of sessions.

Sometimes we find that a child in educational psychotherapy is constantly bringing up charged material and is, by bringing it up, reflectively, symbolically, or with rich play associations, crying out for an interpretive therapy. If this happens early in therapy, we have misunderstood the child's level of functioning and the child's readiness to utilize a different therapy. In such a case we can switch the therapy. It more often happens that a child, after a period of educational psychotherapy, is signalling his newfound readiness for interpretive therapy by bringing up more and more symbolic and historically meaningful dynamic material with which he can deal. This poses the more frequent problem to the educational psychotherapist of how to deal educationally rather than interpretively with the material.

In another example, a child (whose sister was the third generation battered child in this family) was about to be placed in an institution for children because her mother had gone away. She had been seen before this placement and after by the educational psychotherapist. Just before placement she had great difficulty in talking about the situation, but she began an activity of jumping down from a table onto her knees and hurting her knees each time. The educational therapist's reaction was to tell her she did not want her to hurt herself. The educational therapist expressed her interest in and concern with the child by her statement. She also spoke about the phenomenon of children who have a hard time talking about or letting someone help them with their troubles. In the session she factually discussed the forthcoming placement and told her she knew it was hard to talk about. The issue of her hurting herself in this

way was not connected to her being hurt by having to go into the children's institution. Similarly her hurting herself as her mother used to hurt her sister, and the hope that this might restore mother to her, was not interpreted. (Also atoning for her guilt as the non-battered child was not stated.) Over a period of time this therapist made it clear to the child by her constant concern and interest that she wanted to help her and she gave the child a chance of experiencing a warmth and closeness and the opportunity to communicate her sadness and guilt at a level other than by hurting herself. This unwillingness and inability to communicate were prime initial problems of this child. She atoned for the guilt of the survivor by making herself unlikable in the institution in which she was placed. This too was worked with by the educational psychotherapist who continued to see her after her placement. The therapist's acceptance of her, combined with social reality testing in dealing with these issues helped her to a less self-punitive adjustment. The educational psychotherapist played another role in that she helped the child to understand separation from her sister (who was, by design, placed in another area of the institution), even as she refused to condone it and worked with the institution to change this policy.

Often the educational psychotherapist has literally and figuratively a feeding role. Giving to a needy child rather than interpreting the insatiability of the child's needs. This is carefully controlled lest the educational psychotherapist only feeds, when emotionally and educationally the child is able to accept some frustrations and to move beyond this.

In summary, the educational psychotherapy process attempts to operate at the interface between education and psychotherapy, an interface which involves the transformation of psychological energy states into channelled,controlled,organized,secondary process states. In that transformation there is therapeutic value, and in that transformation the services of an educator are often more skillful than those of other therapists. With some children the emphasis will be on an affirmation of,or help with,firmer reality testing where this is a particular problem. The educational therapist's function as an auxiliary to the child's frail ego is an essential part of the therapy. The components of catharsis, recall, sharpening and correcting of perceptions, correction of projections and emphatic insistence upon adaptation to everyday reality are all parts of the work of educational psychotherapy.

This method is particularly appropriate for the young age group in which abstract thinking and concept formation is nascent, in which secondary process is nascent, and in which the beginnings of latency can often be fostered, with non-interpretive help towards resolution of the Oedipal phase through transformation of the hot passions of the young child into the educated channels of latency impulse discharge.

The hot passions of the pre-Oedipal child are similarly helped by channelling into areas which help the child to develop relationships, socialization, and involvement in learning.

THE ROLE OF THE EDUCATIONAL PSYCHOTHERAPIST: BECOMING AN EDUCATIONAL THERAPIST:* In the past, to the best of our knowledge there has not been a systematic training program for training in educational psychotherapy for preschoolers as described here. There is a small existing number of extremely talented educational psychotherapists for preschoolers who have drifted into this field because of the need perceived by them and by concerned child psychiatrists. Training has not been a formal one although in some cases it has consisted of an excellent preceptorship.

In this program we have evolved a formal two year training in which each trainee spends a minimum of twelve hours a week. Six of these hours at least are spent working with children and their families under educational and psychiatric supervision, and six hours are didactic and supervisory. The psychological supervisory training consists of weekly case seminars in large (12 persons) and small (3 persons) groups; and weekly educational supervision in which careful attention is given to maintaining the appropriate educational approach and techniques to help carry out the psychological goals. The didactic training consists of seminars in child pathology in a developmental framework, and in parent guidance. Each trainee must have treated at least three children of various diagnostic categories and their parents over the two year training period and must have participated in the evaluation process with observations and brief trial therapies. All trainees are welcome to participate in other conferences in the Center for Preventive Psychiatry. Some of these are intake, crisis intervention and therapeutic nursery. Being part of a psychiatric clinic program undoubtedly facilitates the training and the change of role perception by the teacher.

Trainees are screened by us both for educational training and for psychological fitness for this work. We have a requirement that our trainees have New York State Certification in Early Childhood or its equivalent. In individual cases of particularly appropriate experienced teachers who do not have certification, we encourage them to get the certification while being trained here. For this purpose we are working with Manhattanville College to develop a cooperative program.

It is our contention that the training of teachers should include more background in providing psychological understanding of child and parent functioning, and in helping teachers to utilize this in working educationally with parents and children, as part of the normal nursery school functioning of a good teacher. This point of view has been elaborated in the Stein, Beyer article. The old view of the nursery school teacher as a glorified babysitter who does not yell at children is outdated and unacceptable today. With the tremendous need for services for young children, it is essential that the nursery school teacher take on more of a role of guiding and assisting parents and children in the developmental process and in the mental health concepts of child rearing. For this there should

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*The organizing and conceptualizing of the program was greatly facilitated by Gilbert Kliman, M.D., Director of the Center for Preventive Psychiatry.

be more initial training and more supervision by professionals in the nursery schools and day care centers.

There is a double problem for teachers who wish to become educational psychotherapists. Not only must they realize their professional competence in working with and understanding preschool children and their families, but they must accept a more assertive professional role than has been their's in the past. Several teachers initially accepted inappropriate times, places and arrangements for parent guidance sessions, lest they impose on the parents' good nature. They would report, "She let me come to see her," in describing their sessions. For many of our teachers this process had already begun, as they were therapeutic nursery classroom educators and part of clinical teams. It is a particular problem when we try to upgrade the skills of day care center teachers while they are still teaching in the centers.

It is our expectation that some of our graduates will continue in day care centers, functioning partially as teachers and mental health resource persons as well as doing educational psychotherapy. Such a career involves not only their changing view of themselves as new professionals, but learning to deal with the feelings of other professionals and para-professionals who must now accept them in a new, enhanced role. This sort of problem is being dealt with by working longitudinally with members of day care centers where we have trainees. We work with the director, teachers, teacher-aides, right down the line to help them to understand the educational psychotherapy process and to help them to accept the change in status of the new professionals.

We have been aware of the tendency of would-be analysts who are untrained for this but who tend to emulate analytic therapists. This is one of the pitfalls against which we guard as must every program involving changing the functioning and status of professionals.

On the completion of two years of training the educational psychotherapist can function in various ways. She can go into schools and day care centers to function as an educational therapist and in addition as a mental health resource person, running seminars, teaching and bringing her psychological orientation to bear on the educational and parent guidance processes. In this work we consider continued psychological supervision necessary and appropriate. There is as yet no certification in New York State for educational psychotherapists, but we are in touch with officials and are trying to develop it. In her new professionalism, the teacher utilizes the receptivity developed in teaching or in therapeutic nursery work (Ronald, D. and Kliman, G. 1970). In addition to this, as a mental health professional working with complicated, chaotic, multi-problem, primitively functioning patients and their families, they must also serve other functions. We find that it is uneconomical of time and personnel, and unfeasible in terms of the psychological needs of the patients to involve other professionals to do narrow parts of the work with these families. For instance we cannot call in a social worker to relate anew with the family every time there is a problem related to other agencies, school, day care

centers, or socio-economic needs. Consequently the educational psychotherapist has learned, of necessity to function in these areas too. The therapist can function as ombudsman with other agencies in the interests of the child and the family, helping coordinate the efforts of the agencies and schools and helping them to understand the holistic picture (Miller, M. 1972).

A special problem in the training of teachers has to do with their inexperience in reporting their interactions with patients and families in the supervisory process. This can be hard for them, more so than for other professionals who have learned this method throughout their training.

FUNCTIONING OF THE EDUCATIONAL PSYCHOTHERAPIST IN CHILD CRISIS:
At the Center for Preventive Psychiatry we are particularly interested in working with children in crisis. We have already written about the work with children in constant crisis as in multi-problem chaotic family situations. In addition there are discreet crises of life such as death, divorce, illness, etc. In the Stein, Beyer article the handling of these cases is referred to, and the importance of the teachers' involvement in guiding the parents and dealing with the child's play and verbal communications is described. Some of the issues of dealing with child crises are described in Stein, 1970, "The Function of Ambiguity in Child Crises."

The educational psychotherapist functions as a communicator, listener, encourager of catharsis by word or play. In certain crisis situations it can be helpful to have brief confrontative work done with the child about some of the feelings related to the crisis. For instance, guilt, anger, conscious restorative fantasies and the like after the death of parent or grandparent should, in our opinion, be brought out when they are readily available as they frequently are. See Kliman et al. "Facilitation of Mourning in Childhood," 1968. Sometimes in such crisis situations a more confrontative role is taken by the educational psychotherapist. The alternative would be to have the child referred for a brief preventive psychotherapy to an analtic psychotherapist to assist in the crisis situation. It is our experience that it is preferable to take advantage of the already built relationship with the educational psychotherapist and to have this therapist take that role. We do this under careful, psychiatric supervision in which a line of confrontation and an understanding of the appropriate limits of interpretation are rigidly controlled and carefully scrutinized here as in all other educational psychotherapeutic situations. Even in such crisis situations it is interesting how often an educational handling, using universalizing, reality testing and the like can be the essential tools needed. We find that using the educational psychotherapist in this way is very similar to working with a child through a parent in a crisis.

CLINICAL MATERIAL: We have chosen two families to present as clinical examples of the educational psychotherapy process. One involves an ego-deviant child, the other a child with a non-deviant ego and a much higher level of functioning. These two children are chosen to give some idea of the scope and range of patients seen.

The ego-deviant child is, Ira. T. Ira, age 5.5 at the time of referral was older than most of our educational psychotherapy patients. The range of such patients at the Center is from the age of two to six. Ira was referred because he was confused, agitated, unable to adjust to regular nursery school and difficult to manage at home. The parents stated that they wanted a better understanding of the child in hopes they could raise him better. In a nursery school he liked the children but could not play with them. He could not perform the simple tasks of play unless he was in a one-to-one relationship. At the same time he could read and do first grade level flashcards. At home the only TV programs that engrossed him were quiz programs. He often read signs, including words that were new to him. The school felt that they could not do justice to the child and that he needed a specialized setting. His speech was barely comprehensible, there was echolalia, he frequently talked to himself as though hallucinating, and he panicked at new situations as though he felt the world outside his home was a bad world. The parents felt that he was exceedingly anxiety-ridden and didn't know how he could trust anyone other than themselves.

Although there was initially a question of organic brain damage, subsequent neurological examinations were negative.

The mother is a bright 32-year old woman, mildly depressed, very articulate, and quite concerned with her ambivalent feelings about Ira. She showed a tendency to jump from authority to authority, leaning on them, then leaving to search out another authority to help her with her guilt about this child's functioning. She has been reluctant to involve herself in therapy although such referral has been a continuing goal of the treatment.

The father is a bright and articulate man who feels that their life revovles too much around this child (there is also a daughter, two) and that it is sometimes all his wife can talk about. He finds his son difficult and he complains about this with less guilt than does his wife. He has also refused treatment in the past although a goal of the educational psychotherapy at its inception was to help him also to go into his own individual treatment.

The initial approach was for a long period of observation, ruling out of organic brain damage, and providing guidance for the parents. It was felt that Ira needed a gentle, consistent object relationship in which he could learn boundaries, and channel his impulsivity to more age appropriate activities. He also needed help in understanding areas of confusion. It was not felt that an interpretive therapy could be helpful at that time. The child was taken on in educational psychotherapy treatment three times a week on a one-to-one basis and the parents were to be seen once a week in guidance.

After some months of educational psychotherapy, the therapist* reassessed her goals. They were to help him to: 1) increase his contact with an extrafamilial person, 2) to withdraw less into fantasy, 3) to communicate more verbally, and 4) to have a better touch with reality. With the parents her goals were to help them with their guilt over "doing this to Ira," to help them to accept that they were entitled to have a life with one another and with their younger daughter. They also were to be helped by the educational psychotherapist to cope with Ira's anxiety rather than to probe the reasons for the anxiety. This is a family with some smattering of psychological insight who tend to psychologize in a way that is not helpful for them or this child. An added goal was to help them adjust to the fact that Ira may never be normal but that there can be a life for them and him within the limits of his disturbance.

The following is a brief description of a session with Ira to give a flavor of what goes on with this child. In the past he didn't talk but after some months of encouragement to talk and of being talked to directly by the educational psychotherapist in a non-anxious fashion, he began to respond.

This day he asked if he was going to see Mrs. Miller today and his mother said, "Yes." Lately he has said goodbye when she leaves (since she has learned to do likewise) and sometimes he kisses her. This he hadn't done in the past. At the beginning of this session the child came over to the therapist with a book, "Are You My Mother?" She read this to him, involving him in the reading, discussing it with him, not directly alluding to the similarity between the longing for the mother of the character in the book and his own neediness for mothering. After being ouside for a while on the playground to which he had led her, he came back into the nursery classroom and took her to the piano. He said, "Some balla lay," meaning play a song. She had been singing to him a great deal lately and he enjoys it. She sat at the piano and played the song. He seemed very pleased and very happy and he went over to the books to listen. He read the books, sang along with her, and as he did so he was arranging the books on the shelf.

At one point he came and played the piano himself sitting on her lap. They were playing "Old MacDonald Had a Farm," and suddenly he began singing it quite clearly. He seemed surprised and embarrassed by his capacity to do so and immediately left her and ran to the clothing rack where he grabbed a stethoscope. Previously when he had done this he would hold the stethoscope up to his eyes and dangle it in front of them in a bizarre fashion similar to behavior he had shown at first. This time he put the earpiece around his neck and took the other end and listned to his own chest. The special teacher went to him, talked about the stethoscope and how it worked. She pointed to the book about the doctor and showed him the stethoscope.

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*Mrs. Marjorie Miller

After a time he became anxious in the play with the stethoscope (possibly related to feelings about doctors and bodily injury) and wanted to go outside. Later in the session he wanted a peanut butter sandwich and pointed to it. The teacher urged him to say exactly what he wanted. She said that, when people want to have something they can say, "I want one." He came to her and said, "I want one," and each time, with some pleasure, he could say, "I want one," to which she then responded.

This child was in educational psychotherapy for approximately two years. His speech improved greatly. The family was immensely relieved when it was found that his neurological exam was negative as this had been an unspoken bugaboo in the house for some years. He was placed in speech therapy by the parents who felt that this was really what he needed. It was only when the educational psychotherapist firmly insisted on the special importance of her approach despite it's being less concrete and less easily understood than the speech therapy, that the parents agreed not to run away from this therapy too (as they had threatened to do in the past). In this instance the therapist confronted and overcame certain of her own doubts about the validity of what she was doing.

Ira improved greatly in his speech, his relatedness, his ability to function in the classroom. He went on to a special school for emotionally handicapped children where he continues to improve. Educational psychotherapy was continued to provide support during the transition.

Summary: This is a child similar to many who are treated at centers interested in working with deviant children. Talented teachers under psychiatric supervision at such centers work with great patience, warmth and understanding to help these primitive children on the very primitive level at which they function. Results are sometimes startlingly good when pseudo-retardation and pseudo-autism appear to have been the proper descriptions for their conditions rather than retardation and autism. With this child who was first diagnosed as autistic by the referring agency, we felt that he was deviant and although he could be worked with and has improved, there is a limit to the likely improvement. The parents function much more comfortably with one another, and are less guilty. The father has gone into his own treatment but the mother has avoided doing so, although she benefits from the guidance. The family is functioning well with the younger child. Perhaps the most important effect of educational psychotherapy in this family is for the mental health of this non-deviant younger child who can now be parented better than before.

The next child, Steven, came to us as a 4-year old. He was referred by a nursery school because he was hyperactive, aggressive to other children and having difficulty in school. He seemed to be quite like an older sister, Laura age seven, who was hyperactive, possibly brain damaged and minimally retarded. In addition to these difficulties Steven had just recently learned that he was adopted.

In the last year this child had had multiple separations in the divorce of his parents and the resulting partial loss of his father thereby; in the fact that the mother had gone to work while the grandmother had come to take over his care in the house. The alcoholic father had been very ill with cirrhosis at the time when he was starting nursery school. We were told that this was a young Dr. Jekyll/Mr. Hyde in that he was either very tractable or very difficult in school. He did indeed view himself as being bad in many ways.

The father an impulsive, alcoholic man, agreed to cooperate in brining the child but did not accept psychotherapy for himself. The mother stated a willingness to help although beneath this was a great deal of resentment towards this boy and men in general. She was unwilling, at the time of onset of educational psychotherapy to participate in a psychotherapy of her own. She did accept the idea, however, of guidance on a regular basis with the therapist.

The educational psychotherapy was instituted initially to obtain a clearer picture of this child's developmental status and functioning in a series of twenty sessions. There was a folie a deux quality about him which quickly fell away. He was emulating his minimally retarded, quixotic, aggressive, impulsive older sister who by the nature of her illness and perhaps by her sex (mother being less angry at girls than boys) had attained a predominant role in the family. He continued to imitate girls at times and to dress up in girl's clothing.

After the initial period of evaluative observation, the work consisted of setting up a relationship, as a chance to communicate with a more accepting, non-punitive figure.

Other goals were to help him understand, realistically assess and react to the many external problems with which he had been faced within the last year. An encouragement of appropriate boyish assertiveness was given.

This child took to the educational psychotherapy like a duck to water. His educational psychotherapist* helped him to express some of his feelings about living with his sister, Laura, about his father leaving and about his adoption, as well as to help him with his social reality testing and impulse control. He became less impulsive, more masculinely assertive and daring although his predilection for female garb showed itself from time to time. The mother tacitly enjoyed and fostered this. In working with him we noted an interesting phenomenon. He told things that happened to him in a markedly vague way and wasn't able to do anything but describe

*Mrs. Marilou Conner

the general situation. One day he said he had played baseball with his daddy and that he had been spanked by his mommy for going into the garden. In each of these instances when his therapist asked the details about it he looked very confused, blank, and surprised, as though not sure where to go next in his thinking about it and in describing it. The therapist followed it through in each of the instances asking questions to try to flesh out the skeleton of the incidents with him and for him.

We believe this boy experiences many events in this confused and vaguely generalized way. The defense was probably very much like that of depersonaliziation, but was not successful. Possibly in this instance his defense of vague generalization occurred because of the anxiety and over-excitement of playing ball with his father, as well as his longing for closeness to the father. It was such a special event that he cannot do more than marvel and wonder at it while it is going on and certainly in retelling it. Similarly, when being hit by his mother, he may have been so upset and so afraid that he reacted in this defensive way. An important part of his educational psychotherapy is to help him to participate more fully, personally, realistically and less abstractedly in these events.

This is a child who was seen in educational psychotherapy for a relatively short period of time. After seven months of such therapy he was placed in a therapeutic nursery at the Center where he had the additional experience of socializing with other children and relating to another teacher.

Following the year in the therapeutic school he is able to go into a normal classroom. At this time he continues to show some difficulties. He knows when he behaves unacceptably, is able to verbalize why he does it, but he still has difficulty in functioning with age adequate controls. At times a tendency to fetishism remains in his dressing in girl's clothing, but for the most part he is not a feminine boy. This child came a long way from being a rejecting, aggressive, highly anxious, extremely infantile child who lagged developmentally. Now other issues require attention including further help with his sexual identity and the lagging Oedipal development, as well as the continued impulsivity. On the basis of these continuing difficulties, and because of his ability to stand frustration and to relate much better than before, it was felt that he could now function in an analytic psychotherapy and needed this for the resolution of internalized difficulties. Consequently, he has been transferred into an analytic psychotherapy.

SUMMARY: These clinical examples concern two of the more than forty patients treated by educational psychotherapy over the past two years. Other cases which we could describe and show movies of involve extremely autistic children who were seen as part of a continuing evaluation, to determine how far they could progress in an educational psychotherapy program, or whether they would need a fuller program than the hour a day which we could provide. Other children we have worked with are extremely maternally deprived.

Another child who will be reported on in the future is a 2-year old girl overly involved with her father, who has custody of her, but showing no signs of emotional disturbance at this time. This child is being seen in educational psychotherapy as a preventive measure to help her handle the separations from the father and to help him to lessen his excessive involvement and seductive behavior with her.

It is expected that this child will have more difficulty as she separates and moves into forthcoming developmental stages. It is particularly expected that the negotiation of the Oedipal phase will be exceedingly difficult because of the excessive involvement with the father and the insufficient involvement with the highly disturbed drug addict mother. In this case it is expected that the educational psychotherapy will preventively maintain a presence in this family for a prolonged period of time. In addition the educational psychotherapist will be giving guidance to both parents and working with other social agencies who are involved with this complicated family situation. A particularly relevant area for educational psychotherapy is the work with drug addicted families and their children for whom preventive intervention of a non-analytic type is particularly useful.

In summary, this paper describes a training program for training educational psycotherapists. They are teachers who are trained to work one-to-one with preschool children under psychiatric and educational supervision. The children range from those with developmental lags, pseudo-retardation, and maternal deprivation, to inability to exercise impulse control. For these children the particular expertise of the teacher when blended with the psychological understanding produces a fortuitous therapeutic mode. This is not a new mode, but we believe that what is new here is the systematic attempt to develop a training program for this type of therapy. We hope that more such special educators will be systematically trained to help fill a very great unmet need for their services.

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